AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1
ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER ELOISE GÓMEZ REYES, ACTING CHAIR

MONDAY, MARCH 18, 2019

2:30 P.M. - STATE CAPITOL ROOM 444
(PLEASE NOTE ROOM CHANGE)

ITEMS TO BE HEARD

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LIST OF PANELISTS IN ORDER OF PRESENTATION

2240 DEPARTMENT OF HOUSING AND COMMUNITY DEVELOPMENT
4260 DEPARTMENT OF HEALTH CARE SERVICES
4560 MENTAL HEALTH SERVICES OVERSIGHT & ACCOUNTABILITY COMMISSION

ISSUE 1: HOMELESSNESS AND MENTAL ILLNESS

PANELISTS

- **Mark Stivers**, Acting Deputy Director, Financial Assistance, Department of Housing and Community Development
- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Toby Ewing**, Executive Director, Mental Health Services Oversight and Accountability Commission
- **Toni Tullys**, Director, Behavioral Health Services, Santa Clara County, Member, County Behavioral Health Directors Association of California Governing Board
- **Jenny Nguyen**, Finance Budget Analyst, Department of Finance
- **Danielle Brandon**, Principal Program Budget Analyst, Department of Finance
- **Kris Cook**, Principal Program Budget Analyst, Department of Finance
- **Ryan Millendez,** Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

4260 DEPARTMENT OF HEALTH CARE SERVICES
4560 MENTAL HEALTH SERVICES OVERSIGHT & ACCOUNTABILITY COMMISSION

ISSUE 2: SUICIDE PREVENTION OVERSIGHT

PANELISTS

- **Jennifer Kent**, Director, Department of Health Care Services
- **Brenda Grealish**, Acting Deputy Director, Mental Health and Substance Use Disorder Services, Department of Health Care Services
- **Toby Ewing**, Executive Director, Mental Health Services Oversight & Accountability Commission
- **Toni Tullys**, Director, Behavioral Health Services, Santa Clara County, Member, County Behavioral Health Directors Association of California Governing Board
- **Anam Khan**, Finance Budget Analyst, Department of Finance
- **Kris Cook**, Principal Program Budget Analyst, Department of Finance
- **Ryan Millendez,** Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 3: EARLY PSYCHOSIS RESEARCH AND TREATMENT FUNDING AND BUDGET CHANGE PROPOSAL

PANELISTS

- **Jennifer Kent**, Director, Department of Health Care Services
- **Brenda Grealish**, Acting Deputy Director, Mental Health and Substance Use Disorder Services, Department of Health Care Services
- **Toby Ewing**, Executive Director, Mental Health Services Oversight & Accountability Commission
- **Toni Tullys**, Director, Behavioral Health Services, Santa Clara County, Member, County Behavioral Health Directors Association of California Governing Board
- **Anam Khan**, Finance Budget Analyst, Department of Finance
- **Kris Cook**, Principal Program Budget Analyst, Department of Finance
- **Ryan Millendez,** Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 4: MEDI-CAL MENTAL HEALTH SERVICES

PANELISTS

- **Jennifer Kent**, Director, Department of Health Care Services
- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Toby Ewing**, Executive Director, Mental Health Services Oversight & Accountability Commission
- **Toni Tullys**, Director, Behavioral Health Services, Santa Clara County, Member, County Behavioral Health Directors Association of California Governing Board
- **Anam Khan**, Finance Budget Analyst, Department of Finance
- **Kris Cook**, Principal Program Budget Analyst, Department of Finance
- **Ryan Millendez,** Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 5: FOSTER YOUTH: TRAUMA-INFORMED SYSTEMS OF CARE (AB 2083) BUDGET CHANGE PROPOSAL

PANELISTS

- **Jennifer Kent**, Director, Department of Health Care Services
- **Brenda Grealish**, Acting Deputy Director, Mental Health and Substance Use Disorder Services, Department of Health Care Services
- **Anam Khan**, Finance Budget Analyst, Department of Finance
- **Kris Cook**, Principal Program Budget Analyst, Department of Finance
- **Ryan Millendez,** Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 6: UNUSUAL OCCURRENCES-COMPLAINT INVESTIGATIONS AND DISASTER RESPONSE BUDGET CHANGE PROPOSAL

PANELISTS

- **Jennifer Kent**, Director, Department of Health Care Services
- **Brenda Grealish**, Acting Deputy Director, Mental Health and Substance Use Disorder Services, Department of Health Care Services
- **Anam Khan**, Finance Budget Analyst, Department of Finance
- **Kris Cook**, Principal Program Budget Analyst, Department of Finance
- **Ryan Millendez,** Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ITEMS TO BE HEARD

2240 DEPARTMENT OF HOUSING AND COMMUNITY DEVELOPMENT
4260 DEPARTMENT OF HEALTH CARE SERVICES
4560 MENTAL HEALTH SERVICES OVERSIGHT & ACCOUNTABILITY COMMISSION

ISSUE 1: HOMELESSNESS AND MENTAL ILLNESS

PANELISTS

- **Mark Stivers**, Acting Deputy Director, Financial Assistance, Department of Housing and Community Development
- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Toby Ewing**, Executive Director, Mental Health Services Oversight and Accountability Commission
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- **Danielle Brandon**, Principal Program Budget Analyst, Department of Finance
- **Kris Cook**, Principal Program Budget Analyst, Department of Finance
- **Ryan Millendez,** Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE

The purpose of this issue is for the Subcommittee to have a general oversight discussion on the relationship between homelessness and mental illness, and the impacts of financial investments being made, or proposed, to address this issue. As components of this issue and discussion, the Subcommittee has asked the Department of Housing and Community Development to provide an overview of the No Place Like Home Program. Additionally, the Department of Health Care Services (DHCS) will present the Governor's proposal for $100 million General Fund for supportive housing for individuals with mental illness through the Whole Person Care Program.

PROPOSAL

The Budget invests $100 million General Fund (one-time with multi-year spending authority) for Whole Person Care Pilot programs that provide housing services. DHCS will develop a funding allocation methodology for this augmentation that considers various factors, such as prevalence of homelessness, cost of living, and performance. This funding will be used to match local county investments in health and housing services with a focus on the homeless mentally ill population.

BACKGROUND

Whole Person Care Program

The Whole Person Care Pilot (WPC) Program coordinates health, behavioral health (including mental health and substance use disorder services), and social services, as applicable, in a patient-centered manner with the goal of improved beneficiary health and well-being. There are 25 WPC Programs, many of which target individuals who are experiencing homelessness, or who are at risk of homelessness, and have a demonstrated medical need for housing and/or supportive services.

The overarching goal of the WPC Pilots is the coordination of health, behavioral health, and social services, as applicable, in a patient-centered manner with the goals of improved beneficiary health and wellbeing through more efficient and effective use of resources. WPC Pilots provide an option to a city or county (or other local government entity) to receive support to integrate care for a particularly vulnerable group of Medi-Cal beneficiaries who have been identified as high users of multiple systems and continue to have poor health outcomes. Through collaborative leadership and systematic coordination among public and private entities, WPC Pilot entities identify target populations, share data between systems, coordinate care real time, and evaluate individual and population progress – all with the goal of providing comprehensive coordinated care for the beneficiary resulting in better health outcomes.

The No Place Like Home Act

The No Place Like Home Act dedicates $2 billion in bond funding to acquire, design, construct, rehabilitate, or preserve permanent supportive housing for persons who are in need of mental health services and are experiencing homelessness, chronic homelessness, or who are at risk of chronic homelessness. The bonds are repaid by funding from the Mental Health Services Act (MHSA/Proposition 63). Key features of the program include:

- Counties will be eligible applicants (either solely or with a housing development sponsor).
- Funding for permanent supportive housing must utilize low barrier tenant selection practices that prioritize vulnerable populations and offer flexible, voluntary, and individualized supportive services.
- Counties must commit to provide mental health services and help coordinate access to other community-based supportive services.

The population to be served includes adults with serious mental illness, or children with severe emotional disorders and their families, and persons who require or are at risk of requiring acute psychiatric inpatient care, residential treatment, or outpatient crisis intervention because of a mental disorder with symptoms of psychosis, suicidality or violence and who are homeless, chronically homeless, or at risk of chronic homelessness.

At risk of chronic homelessness includes persons who are at high risk of long-term or intermittent homelessness, including persons with mental illness exiting institutionalized settings with a history of homelessness prior to institutionalization, and transition age youth experiencing homelessness or with significant barriers to housing stability.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests:

- The Department of Housing and Community Development (HCD) to present an overview of the No Place Like Home Program;
- DHCS to present the Governor's proposal for $100 million General Fund for supportive housing through the WPC Pilot Programs;
- CBHDA to share information about the mentally ill homeless population from the counties' perspective; and
- The panel to respond to the following:

  1. Does the Administration have an estimate of the size of the homeless mentally ill population in California?
  2. How much of the problem can be addressed by the No Place Like Home Program and by the WPC Pilot Programs (including the proposed increase in funding)?
  3. Does the State have a long-term strategy or plan for developing housing for the total population of mentally ill homeless Californians.
  4. Which WPC programs provide housing services, and therefore will qualify for this new funding?
  5. How have counties responded to the increasing size of the mentally ill homeless population?

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional debate and discussion.

4260 DEPARTMENT OF HEALTH CARE SERVICES
4560 MENTAL HEALTH SERVICES OVERSIGHT & ACCOUNTABILITY COMMISSION

ISSUE 2: SUICIDE PREVENTION OVERSIGHT

PANELISTS

- **Jennifer Kent**, Director, Department of Health Care Services
- **Brenda Grealish**, Acting Deputy Director, Mental Health and Substance Use Disorder Services, Department of Health Care Services
- **Toby Ewing**, Executive Director, Mental Health Services Oversight & Accountability Commission
- **Toni Tullys**, Director, Behavioral Health Services, Santa Clara County, Member, County Behavioral Health Directors Association of California Governing Board
- **Anam Khan**, Finance Budget Analyst, Department of Finance
- **Kris Cook**, Principal Program Budget Analyst, Department of Finance
- **Ryan Millendez,** Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE

In response to rising suicide rates in California (and nationally), the Subcommittee has been exploring and discussing suicide and suicide prevention in California over the past few years. Today's issue is for the purpose of continuing this oversight, receiving updates on various efforts underway, and to continue the conversation on how California can improve its suicide prevention efforts.

BACKGROUND

California Suicide Statistics

The Legislative Analyst's Office provided the following data:

The suicide rate in California rose 14.8 percent from 1999 to 2016 (U.S. Centers for Disease Control).

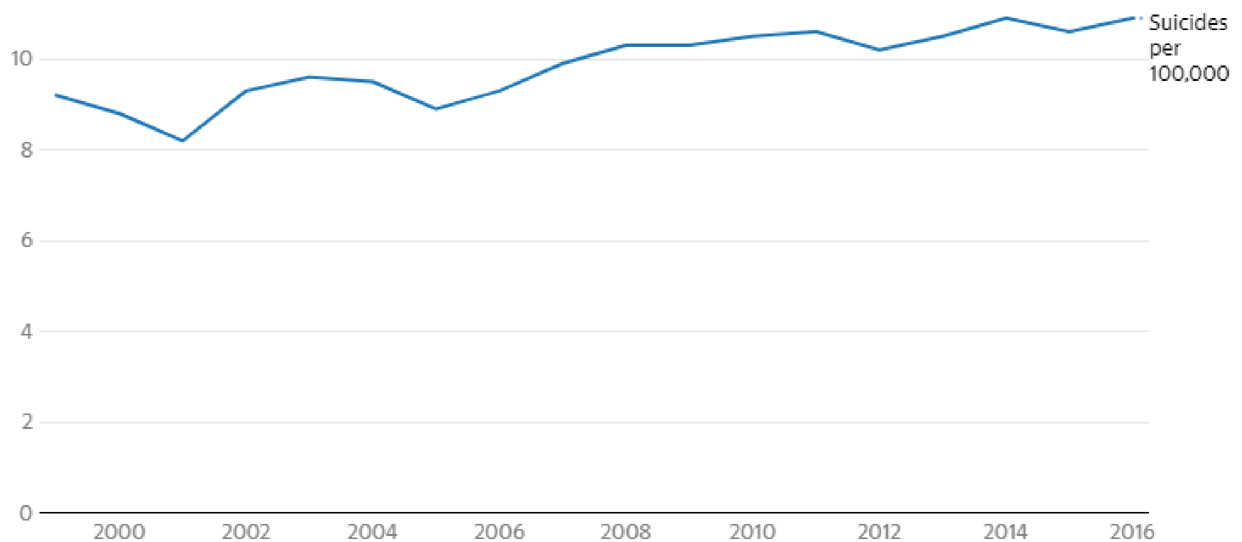
	Change in number of annual suicides	Percentage change in number of annual suicides	**Percent change in age-adjusted death rate**
1996-97 to 2014-16	635	17.9%	**1.0%**
1999-2001 to 2014-16	1,048	33.4%	**9.5%**
2004-06 to 2014-16	904	27.5%	**15.6%**

The following table shows the percentage increase in suicides from 1991 to 2017 by age group:

Age	10-14	15-19	20-24	25-44	45-64	65-84	85+
1991-2017 % Increase	**225%**	**53%**	**38%**	**16%**	**6%**	**58%**	**50%**

The Sacramento Bee (on June 13, 2018) reported that:

- Nearly 4,300 Californians killed themselves in 2016, a 50 percent increase from 2001, according to the latest figures from the U.S. Centers for Disease Control.
- The suicide rate rose from 8.2 suicides per 100,000 residents to 10.9 suicides per 100,000 residents from 2001 to 2016.
- Suicide rates are particularly high in rural parts of California where mental health care is scarce. Trinity County saw an annual rate of more than 30 suicides per 100,000 residents between 1999 and 2016, roughly triple the statewide rate.



The *San Francisco Chronicle* (on February 8, 2019) reported that:

- Suicides in the U.S. rose by 33 percent from 1999 to 2017.
- For people under 35, suicide is the second leading cause of death after unintentional injuries.

Statewide Suicide Prevention Strategic Plan

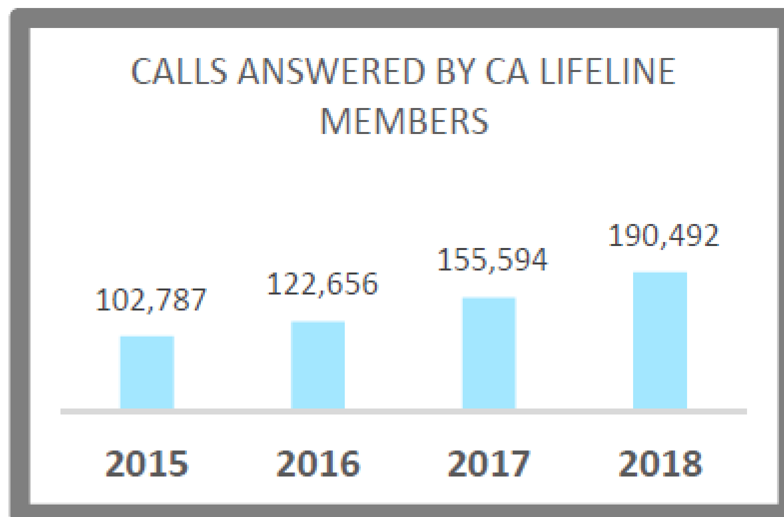
In 2017, under the leadership of Assembly Budget Subcommittee #1, the Legislature adopted, and the 2017 budget includes $100,000 (MHSA State Administration Fund) to support, the following Supplemental Reporting Language directing the Commission to develop a Statewide Suicide Prevention Strategic Plan:

> ***"State Suicide Prevention Strategic Plan***. The Mental Health Services Oversight and Accountability Commission (Commission) shall develop and write a State Suicide Prevention Strategic Plan. The Commission shall provide the suicide prevention plan to the Legislature by July 1, 2018. If the Commission cannot meet this deadline, it shall notify the Senate and Assembly Budget Committees by May 31, 2018.
>
> The Commission shall form an advisory group to help the Commission develop the suicide prevention plan. The advisory group shall include suicide experts, interested constituency groups, state and local agencies, and any other individuals deemed appropriate by the Commission.
>
> Development of this plan may include all of the following:
>
> - A competitive or noncompetitive contracting process in order to contract with an entity other than the Commission to develop and write the plan.
> - Extensive review and analysis of social science research on causes, methods, and effectiveness of prevention strategies of suicide.
> - Establishment of public-private partnerships for purposes of development of innovative prevention strategies and to maximize resources.
> - Exploration and development of the role of social media, and establishment of partnerships between social media, community organizations, and state and local governments to develop innovative prevention strategies and to maximize resources.
> - Public hearings or meetings in various locations in the state in order to generate interest, discussion, and resources for this project.
>
> The State Suicide Prevention Strategic Plan shall include the following:
>
> - A summary of research and literature on suicide and suicide prevention.
> - A summary of California-specific suicide data.
> - A summary of best practices and innovative models from other states and countries.
> - An assessment of existing suicide prevention resources in California.
> - An assessment of unmet needs, missed opportunities, and unique challenges in California.
> - Recommendations on prioritizing suicide prevention strategies and interventions in California."

Suicide Hotlines

The 2016-17 budget included $4 million one-time, the 2017-18 budget included $4.3 million one-time, and the 2018-19 budget includes $4.3 million ongoing to help fund California's 10 National Suicide Prevention Lifeline Centers (Lifeline). Initially launched by the Substance Abuse and Mental Health Services Administration (SAMHSA), there are over 160 accredited Lifeline members in the U.S. who follow research-informed best practices. California's Lifeline centers include one of two in the nation with Spanish speaking counselors 24/7 and one of three that answers the Lifeline's Disaster Distress Helpline. All centers follow up with high-risk callers.

DHCS selected Didi Hirsch Mental Health Services in Los Angeles to act as the lead contractor and to administer these funds; they executed the contract in July 2018 for 2018-19. Didi Hirsch has invoiced DHCS on a monthly basis and began receiving payment in November 2018. Didi Hirsch reports that all centers have used the funds to increase their capacity to handle the growing call volume on the Lifeline. With increased advertising and media attention, the calls/chats answered by California's Lifeline centers increased 85% between 2015 and 2018. In February 2019, DHCS notified Didi Hirsch that the contract had been extended for FY 19/20 for $4.3 million.



Didi Hirsch reports that the counties have invested millions of dollars advertising the Lifeline number, as have universities, insurance companies, etc. In addition:

- Any Google search that is suicide-related brings up the Lifeline number;
- Facebook responds with the number when posts contain key words associated with suicide;
- When iPhone's Siri hears suicide mentioned, "she" refers the speaker to the Lifeline;
- The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires all facilities to give it to every suicidal person they serve.

Golden Gate Bridge Suicide Deterrent System

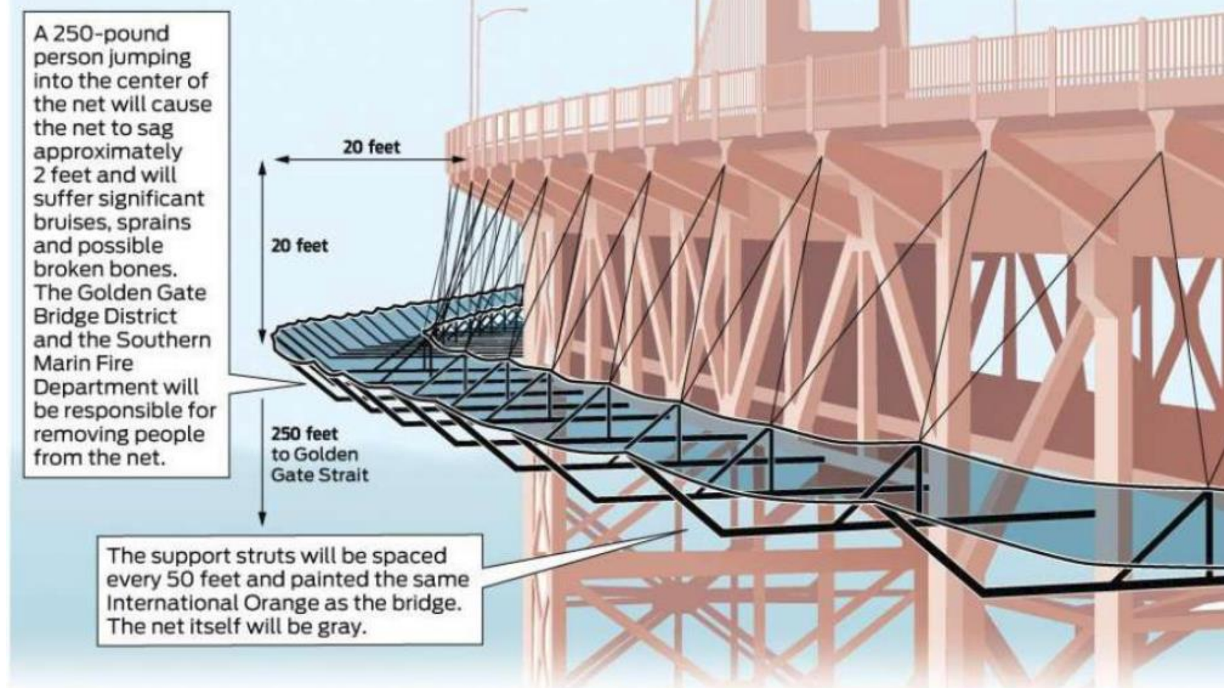
After years of intense public debate, the Golden Gate Bridge Authority Board approved construction of a suicide net on the Bridge in 2008, and spent the next approximately 9 years raising $211 million for the project. According to the *San Francisco Chronicle* (2/8/19), the project budget is supported by the following:

- Metropolitan Transportation Commission -- $74 million
- California Department of Transportation -- $70 million
- Golden Gate Bridge, Highway and Transportation District revenue -- $60 million
- Proposition 63 State Administration Funds (approved through the 2014 Budget Act) -- $7 million

The project groundbreaking took place in April 2017, actual construction began in August of 2017, and the Bridge Authority expects the project to be completed in January 2021.

According to a February 2019 *San Francisco Chronicle* article:

- More than 1,700 people are known to have killed themselves by jumping off of the Golden Gate Bridge, including at least 27 in 2018.
- The Golden Gate Bridge is the second most popular suicide destination in the world, behind China's Nanjing Yangtze River Bridge.
- Foot, bike and car patrols on the Bridge saved 187 lives last year.
- On average, one person every 13 days dies jumping from the Bridge.



Graphics by John Blanchard / The Chronicle

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the Oversight and Accountability Commission to provide an update on its development of a Statewide Suicide Prevention Strategic Plan, and provide an update on the construction of the Golden Gate Bridge suicide deterrent system.

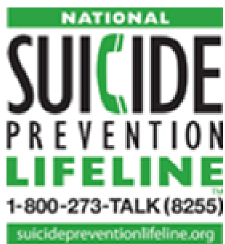
The Subcommittee requests CBHDA to share any knowledge of county suicide prevention efforts.

Finally, the Subcommittee requests DHCS to provide an update on the distribution of funds to support suicide hotlines and respond to the following:

> The Administration shared with staff that DHCS entered into a contract with Didi Hirsch Mental Health Services, and described the implementation of an invoice-based reimbursement system for reimbursement using the $4.3 million included in

the 2018 budget. However, the disposition of the $8.3 million appropriated through the 2016 and 2017 Budget Acts remains unclear. Would the Administration please explain where these funds are located at this point in time, and what the reasons are that they have not been allocated to support suicide hotlines.

Staff Recommendation: Subcommittee staff recommends no action at this time as this is an oversight issue.



If you or someone you know is in crisis, please call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255). (Not DHCS)

Si usted o alguien que usted conoce esta en una crisis por favor llame a la Red para la Prevención del Suicidio al 1-888-628-9454. (Not DHCS)

ISSUE 3: EARLY PSYCHOSIS RESEARCH AND TREATMENT FUNDING AND BUDGET CHANGE PROPOSAL

PANELISTS

- **Jennifer Kent**, Director, Department of Health Care Services
- **Brenda Grealish**, Acting Deputy Director, Mental Health and Substance Use Disorder Services, Department of Health Care Services
- **Toby Ewing**, Executive Director, Mental Health Services Oversight & Accountability Commission
- **Toni Tullys**, Director, Behavioral Health Services, Santa Clara County, Member, County Behavioral Health Directors Association of California Governing Board
- **Anam Khan**, Finance Budget Analyst, Department of Finance
- **Kris Cook**, Principal Program Budget Analyst, Department of Finance
- **Ryan Millendez,** Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

DHCS requests a one-time augmentation of $25 million General Fund (GF) with accompanying 2019-20 Budget Bill language, including up to $1 million limited-term (LT) resources for state operations. This funding will be used to administer up to $25 million in GF to qualified grantees, including but not limited to: county mental health plans, nonprofit organizations, behavioral health providers, or academic institutions to identify and support appropriate interventions for California youth experiencing the signs of early psychosis.

BACKGROUND

It is estimated that 50 percent of all mental illness begins by the age of 14 and 75 percent by the age of 24. Psychotic symptoms, such as hallucinations, delusions, unusual or disorganized behaviors or speech, and negative actions such as social withdrawal typically emerge during late adolescence or early adulthood. Untreated psychosis increases an individual's risk of suicide, involuntary emergency care, and poor clinical outcomes leading to a disability in adulthood. The average delay in receiving appropriate diagnosis and treatment for psychotic disorders is 18.5 months following the onset of psychotic symptoms.

There are emerging evidence-based strategies to identify, diagnose, and treat individuals with early signs of serious mental illness, including psychotic symptoms and behaviors. Some of these interventions include cognitive and behavioral psychotherapy, low doses of antipsychotic medications, family education and support, educational and vocational rehabilitation and coordinated case management.

The Governor's Budget proposes $25 million in one-time GF funding in FY 2019-20 to provide grants to support projects that demonstrate innovative approaches to detect and intervene when young people have had or are at risk of psychosis. Of the funds appropriated, up to $1,000,000 shall be available to DHCS for administrative costs associated with the distribution of the Early Psychosis Research and Treatment grant funds, as requested in this proposal.

In order to develop and implement the infrastructure needed to administer the Early Psychosis Outreach, Detection, and Intervention Grant Program, additional resources will be necessary within the MHSD and the Office of Medical Procurement/Contracting Division. The Budget Bill language will allow for limited-term resources to administer a grant program that seeks competitive applications from qualified entities to identify and support appropriate interventions for California youth experiencing the signs of early psychosis. These qualified applicants will be required to provide detailed information regarding the methods, strategies, services and outreach that will be performed using these grant funds. The level of funding granted will depend on workload and applicants' needs.

Grantees will utilize grant funds to:

- Improve access to youth, young adults and their families who are at risk or experiencing psychotic symptoms or diagnosed with a psychotic disorder;
- Demonstrate programmatic effectiveness in client outcomes, including both clinical and non-clinical measures;
- Support families with a family member (youth or young adult) with early psychosis or psychotic disorder through education, counseling and case management;
- Improve an individual's experience in accessing services and building their capacity to support their own recovery and function;
- Describe outreach strategies on identifying and reaching youth, young adults, and impacted families, including a diversity of California populations that reflect different ethnic, sexual orientation, racial, religious, economic status and other marginalized populations.
- Demonstrate sustainability for the period after the grant monies have been expended, including a plan for linking patients with ongoing care needs to other public programs such as Medi-Cal; and
- Reduce a youth or young adult's unnecessary hospitalization or interaction with public safety officials such as juvenile hall or jail.

Administration of such a grant program is expected to require:

- Development of program policies and guidelines;
- Development of a request for application (RFA);
- Development of scoring criteria for the RFA;
- Scoring and review of received RFAs;
- Development and execution of contracts for selected grantees;
- Continuous monitoring of the grant through FY 22-23;

- Regular technical assistance for grantees;
- Review of grantee reports;
- Review and approval of invoices to make payments to grantees; and
- Creation of a final summary report evaluating program outcomes across grantees and assessing the effectiveness of grant funded programs.

Proposed Budget Bill Language:

4260-118-0001—for local assistance, the State Department of Health Care Services…………………………………………………………………………… 25,000,000

Schedule:

(1) 3960050-Other Health-Care Services………………………………….. 25,000,000

Provisions:

1. Of the funds appropriated in Schedule (1), up to $1,000,000 shall be available to the State Department of Health Care Services for the department's administrative costs associated with the distribution of the Early Psychosis Research and Treatment grant funds. The Department of Finance may authorize the transfer of expenditure authority from Schedule (1) of this item to Schedule (1) of Item 4260-001-0001. The funds transferred from this item shall be available for encumbrance or expenditure until June 30, 2024.

2. The funds appropriated in this item shall be available for encumbrance or expenditure until June 30, 2024.

AB 1315 (Mullin, Chapter 414, Statutes of 2017)

AB 1315 establishes the Early Psychosis Intervention Competitive Selection Process Plus Program and an advisory committee to the Mental Health Services Oversight and Accountability Commission to encompass early psychosis and mood disorder detection and intervention. The bill provides that the implementation of the grant program and adoption of regulations be contingent upon deposit into the Early Psychosis Detection and Intervention Fund of at least $500,000 in non-state funds for the purpose of funding grants.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this proposal, requests the Oversight and Accountability Commission present an overview and update on the Early Psychosis program established through AB 1315, and requests CBHDA to discuss what is known about effective early psychosis programs and efforts underway by counties.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional debate and discussion.

ISSUE 4: MEDI-CAL MENTAL HEALTH SERVICES

PANELISTS

- **Jennifer Kent**, Director, Department of Health Care Services
- **Mari Cantwell**, Chief Deputy Director, Health Care Programs, Department of Health Care Services
- **Toby Ewing**, Executive Director, Mental Health Services Oversight & Accountability Commission
- **Toni Tullys**, Director, Behavioral Health Services, Santa Clara County, Member, County Behavioral Health Directors Association of California Governing Board
- **Anam Khan**, Finance Budget Analyst, Department of Finance
- **Kris Cook**, Principal Program Budget Analyst, Department of Finance
- **Ryan Millendez,** Fiscal & Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE

California has a decentralized public mental health system with most direct services carved out of managed care and provided through the county mental health system. Counties (i.e., county mental health plans) have the primary funding and programmatic responsibility for local mental health programs. This funding includes 1991 and 2011 realignment funding, Medi-Cal Specialty Mental Health General Fund and Federal Funds, and Mental Health Services Act (Proposition 63) funding. Mental health funding to counties in 2018-19 totaled approximately $7.6 billion.

BACKGROUND

California has three systems that provide mental health services to Medi-Cal beneficiaries:

Managed Care Plans (MCPs) - Effective January 1, 2014, SB 1 X1 (Hernandez), Chapter 4, Statutes of 2013-14 of the First Extraordinary Session, expanded the scope of Medi-Cal mental health benefits and required these services to be provided by the Medi-Cal Managed Care Plans (MCP), excluding those benefits provided by county mental health plans. Generally, these are mental health services for those with mild to moderate levels of impairment. The mental health services provided by the MCPs include:

- Individual and group mental health evaluation and treatment (psychotherapy)
- Psychological testing when clinically indicated and medically necessary to evaluate a mental health condition
- Outpatient services for the purposes of monitoring drug therapy
- Outpatient laboratory, drugs, supplies and supplements
- Psychiatric consultation

County Mental Health Plans (MHPs) - California provides Medi-Cal "specialty" mental health services (SMHS) under a federal Medicaid Waiver that includes outpatient specialty mental health services, such as clinic outpatient providers, psychiatrists, psychologists and some nursing services, as well as psychiatric inpatient hospital services. Children's specialty mental health services are provided under the federal requirements of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit for persons under age 21. County mental health plans are the responsible entity that ensures specialty mental health services are provided. Medi-Cal enrollees must obtain their specialty mental health services through counties.

MHPs are responsible for providing SMHS to Medi-Cal beneficiaries who meet SMHS medical necessity criteria. SMHS are delivered through 56 county mental health plans (Placer and Sierra Counties and Yuba and Sutter Counties operate two separate dual-county combined MHPs). Medi-Cal beneficiaries that meet medical necessity criteria for SMHS are entitled to receive medically necessary SMHS from their county MHP, regardless of whether or not they are enrolled in a MCMC plan

Fee-For-Service Provider System (FFS system) - Effective January 1, 2014 the mental health services listed below are also available through the Fee-For-Service/Medi-Cal provider system:

- Individual and group mental health evaluation and treatment (psychotherapy)
- Psychological testing when clinically indicated and medically necessary to evaluate a mental health condition
- Outpatient services for the purposes of monitoring drug therapy
- Outpatient laboratory, drugs, supplies and supplements
- Psychiatric consultation

	MCMC Plan	MHP - Outpatient	MHP– Inpatient

SERVICES	Mental health services provided by licensed mental health care professionals (as defined in the Medi-Cal provider bulletin) acting within the scope of their license:
	• Individual and group mental health evaluation and treatment (psychotherapy)
	• Psychological testing when clinically indicated to evaluate a mental health condition
	• Outpatient services for the purposes of monitoring medication therapy
	• Outpatient laboratory, medications,* supplies, and supplements
	• Psychiatric consultation
		• Mental Health Services
		  ○ Assessment
		  ○ Plan development
		  ○ Therapy
		  ○ Rehabilitation
		  ○ Collateral
		• Medication Support Services
		• Day Treatment Intensive
		• Day Rehabilitation
		• Crisis Residential Treatment
		• Adult Residential Treatment
		• Crisis Intervention
		• Crisis Stabilization
		• Targeted Case Management
		• Intensive Care Coordination
		• Intensive Home-Based Services
		• Therapeutic Foster Care
		• Therapeutic Behavioral Services
			• Acute psychiatric inpatient hospital services
			• Psychiatric Health Facility Services
			• Psychiatric Inpatient Hospital Professional Services if the beneficiary is in fee-for-service (FFS) hospital

Source: DHCS All Plan Letter (APL) 17-018.

Behavioral Health Realignment Funding

SB 1020 (Committee on Budget and Fiscal Review), Chapter 40, Statutes of 2012, created the permanent structure for 2011 Realignment. SB 1020 codified the Behavioral Health Subaccount which funds Medi-Cal Specialty Mental Health Services (for children and adults), Drug Medi-Cal, residential perinatal drug services and treatment, drug court operations, and other non-Drug Medi-Cal programs. Medi-Cal Specialty Mental Health and Drug Medi-Cal are entitlement programs and counties have the responsibility to provide for these entitlement programs.

Government Code Section 30026.5(k) specifies that Medi-Cal Specialty Mental Health Services shall be funded from the Behavioral Health Subaccount, the Behavioral Health Growth Special Account, the Mental Health Subaccount (1991 Realignment), the Mental Health Account (1991 Realignment), and to the extent permissible under the Mental Health Services Act, the Mental Health Services Fund. Government Code Section 30026.5(g) requires counties to exhaust both 2011 and 1991 Realignment funds before county General Fund is used for entitlements. A county board of supervisors also has the ability to establish a reserve using five percent of the yearly allocation to the Behavioral Health Subaccount that can be used in the same manner as their yearly Behavioral Health allocation, pursuant to Government Code Section 30025(f).

STAFF COMMENTS/QUESTIONS

For many years, the Legislature has grappled with how to assess both access to and quality of care in the Medi-Cal program, in general, and particularly with regard to behavioral health services. This type of information has remained fairly inaccessible, for a host of reasons, and frustration among legislators is growing. As described above, the mental health services for serious mental health conditions are carved out of managed care and counties pay for and manage the delivery of these services. This county-based structure represents a significant impediment to the Legislature holding the state accountable for guaranteeing quality and access for these services. Although mental health services were "realigned" to the counties, thereby becoming a county responsibility, the Medi-Cal program remains a federal program, operated by the state, specifically with DHCS designated as California's single state-Medicaid agency. In other words, the Legislature and DHCS have significant legal and moral obligations to ensure that Medi-Cal services are truly accessible to Medi-Cal beneficiaries and that the services are at least the quality of commercial health care services. Yet, it has proven quite challenging to provide oversight over 58 different behavioral health programs. The Legislature relies on DHCS to conduct this oversight, identify weaknesses and failures of the county MHPs, develop proposed solutions to improve the programs, and to be transparent with this information.

The Subcommittee requests the panel to provide information on access to, and quality of, mental health services provided both by county MHPs and Medi-Cal managed care plans, and respond to the following:

1. How does the state, and how do counties, monitor access to Specialty Mental Health Care?

2. Do the counties have sufficient funding to meet the actual need for Specialty Mental Health Care?

3. Please summarize the critical pieces of information contained in the DHCS mental health Dashboard ("performance outcome system").

4. What are the positive and negative aspects of having a bifurcated mental health system -- bifurcated between managed care and county MHPs, between the state and counties, and between behavioral and physical health care?

5. Please discuss the role and impacts of Proposition 63 funding in the delivery of Medi-Cal mental health services.

Staff Recommendation: Subcommittee staff recommends no action at this time as this is an oversight issue.

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 5: FOSTER YOUTH: TRAUMA-INFORMED SYSTEMS OF CARE (AB 2083) BUDGET CHANGE PROPOSAL

PANELISTS

- **Jennifer Kent**, Director, Department of Health Care Services
- **Brenda Grealish**, Acting Deputy Director, Mental Health and Substance Use Disorder Services, Department of Health Care Services
- **Anam Khan**, Finance Budget Analyst, Department of Finance
- **Kris Cook**, Principal Program Budget Analyst, Department of Finance
- **Ryan Millendez,** Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

DHCS requests 3.0 permanent positions and expenditure authority of $438,000 ($219,000 General Fund (GF) and $219,000 Federal Fund (FF)) for fiscal year (FY) 2019-20, and $411,000 ($206,000 GF and $205,000 FF) for FY 2020-21 and ongoing to implement requirements in Assembly Bill (AB) 2083 (Cooley, Chapter 815, Statutes of 2018).

BACKGROUND

AB 2083 requires DHCS to participate in a newly-established, state level joint interagency resolution team that is responsible for providing guidance and technical assistance to counties. DHCS is required to report information to the Legislature, which includes recommendations pertaining to development of processes for centralized entry, authorization, and access to services; a multi-year plan for increasing the capacity and delivery of trauma-informed care to foster children and youth with intensive needs; and recommendations for a statewide, pooled financing structure. AB 2083 also requires county Mental Health Plans (MHPs) to establish Memoranda of Understanding (MOU). The MOUs will describe the roles and responsibilities of entities that serve children and youth, in foster care, who experienced severe trauma and have extensive, complex, and persistent needs for mental health treatment and supportive services

AB 2083 is built upon the Continuum of Care Reform (CCR) implementation efforts by developing a coordinated, timely, and trauma-informed system of care approach for foster children and youth who have experienced severe trauma. This is achieved by identifying and addressing gaps and delays, in needed services and placement options for these children and youth, to better meet the needs of severely traumatized children and youth in foster care; improve outcomes; and prevent the need for higher-cost interventions. CCR provides the statutory and policy framework to ensure services and supports provided to children and youth in foster care, or at risk of placement in foster

care, are tailored toward the goals of reducing reliance on congregate care; increasing focus on permanency; and building family engagement, service planning, and decision-making through the child and family team process. CCR intends to have children and youth, who must live apart from their biological parents, live in permanent homes with committed adults who can meet their needs, or in Short-Term Residential Therapeutic Programs (STRTPs), to receive necessary mental health services and trauma-informed care.

AB 2083 identifies multiple new tasks, with associated new workload, for DHCS including:

- Joint Interagency Resolution Team Participation and Completion of Work Products
  DHCS is required to participate in a Joint Interagency Resolution Team before June 1, 2019. As part of this team, DHCS is required to provide technical assistance to parties of the MOUs, support the implementation of such MOUs, and provide technical assistance to counties, to identify and secure the appropriate level of services to meet the needs of children and youth in foster care who have experienced severe trauma. DHCS is expected to respond to counties' requests for technical assistance, and therefore intends to develop a process to respond to technical assistance requests, and develop a technical assistance program to support state and local issues related to a population of vulnerable children.

  In addition, DHCS needs to address emerging issues with counties that experience significant challenges in establishing a local framework to implement MOUs. DHCS expects that ongoing coordination and additional staff time will be required to respond to MHP questions, requests (case specific), provide technical assistance, and support efforts between State departments to address the multi-system collaboration.

- Recommendations to the Legislature
  DHCS is required to consult with county agencies, service providers, and advocates for children and resource families to review the placement and service options available to county child welfare agencies and county probation departments; develop recommendations to address gaps in placement types and needed services to resource families; and submit recommendations to the Legislature no later than January 1, 2020. In order to satisfy these requirement, DHCS states that it needs additional resources to conduct research, participate in meetings and workgroups to review placement and service options available to children and youth, develop recommendations, and include MHPs and mental health issues in the report due to the Legislature.

- Multi-Year Plan
  DHCS is required to consult with county agencies, service providers, behavioral health professionals, schools of social work, and advocates for children and resource families to develop a multiyear plan no later than June 1, 2020. The plan should address capacity issues and delivery of trauma-informed care to children and youth in foster care served by STRTPs and other entities. Lastly, DHCS states that additional resources are required to conduct research, and inventory data regarding existing capacity of trauma informed services by county or region, and propose steps needed to increase services if necessary.

- Information Sharing and Privacy Provisions
  DHCS states that it will need to develop a process to share confidential information in a manner that meets with federal law and in accordance with the intent of AB 2083.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS provide an overview of CCR and present this Budget Change Proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional debate and discussion.

ISSUE 6: UNUSUAL OCCURRENCES-COMPLAINT INVESTIGATIONS AND DISASTER RESPONSE BUDGET CHANGE PROPOSAL

PANELISTS

- **Jennifer Kent**, Director, Department of Health Care Services
- **Brenda Grealish**, Acting Deputy Director, Mental Health and Substance Use Disorder Services, Department of Health Care Services
- **Anam Khan**, Finance Budget Analyst, Department of Finance
- **Kris Cook**, Principal Program Budget Analyst, Department of Finance
- **Ryan Millendez,** Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

DHCS requests 8.0 permanent positions and two-year limited-term (LT) resources equivalent to 2.0 positions. The requested resources are expected to allow DHCS to: 1) timely and effectively respond to requests regarding investigations of violations, alleged by the public, against facilities licensed and certified by DHCS Mental Health Services Division (MHSD); 2) address complaints and unusual occurrences that adversely affect the health, safety, and treatment of clients in these facilities; and 3) support the disaster behavioral health response during a natural disaster, mass casualty incident, and emergency preparedness/planning. Federal administrative funding may be available for emergency mental health to support fiscal, program oversight, and data evaluation associated with implementation of the Crisis Counseling Assistance and Training Program. The availability of funding for additional staff would be dependent on the size of the federal grant and the number of counties receiving funds.

Total funding request:

Fiscal Year	Total Funds	General Fund	Federal Fund
2019-20	**$1,577,000**	**$858,000**	**$719,000**
Unusual Occurrences	$1,438,000	$719,000	$719,000
Disaster Response	$139,000	$139,000	$0
2020-21	**$1,487,000**	**$809,000**	**$678,000**
Unusual Occurrences	$1,357,000	$679,000	$678,000
Disaster Response	$130,000	$130,000	$0
2021-22 Ongoing	**$1,059,000**	**$595,000**	**$464,000**
Unusual Occurrences	$929,000	$465,000	$464,000
Disaster Response	$130,000	$130,000	$0

The following chart identifies the positions requested with the corresponding activity.

Division	Request	Activity
Mental Health Services	7.0 permanent positions • 6.0 Associate Governmental Program Analysts (AGPAs) • 1.0 Staff Services Manager I (SSM I)	• Unusual Occurrences
	1.0 permanent position • 1.0 AGPA	• Disaster Response
Office of Legal Services	2.0 two-year LT resources equivalent to 2.0 positions • 2.0 Attorney IIIs	• Unusual Occurrences

BACKGROUND

Unusual Occurrences

MHSD Licensing and Certification Branch (LCB) is responsible for the licensing, certification and oversight of 285 residential mental health programs on a statewide basis, ranging from acute to long-term programs. Specifically, LCB is statutorily responsible for implementing and maintaining a system for compliance with licensing and program certification requirements for the entire range of 24-hour psychiatric and rehabilitation care facilities. These responsibilities involve, but are not limited to, coordination with other state and federal regulatory agencies, counties and stakeholders, conducting onsite reviews, producing written reports and plans of correction related to onsite reviews, conducting criminal background clearances of employees, contractors, and volunteers of the licensed facilities, investigation of Unusual Occurrence Reports (UOR) which are required to be reported to DHCS within 24-hours of occurrence, and the investigation of complaints.

An unusual occurrence is any condition or event which has jeopardized or could jeopardize the health, safety, security or well-being of any patient, employee or any other person while in the facility. MHSD LCB is responsible for implementing civil and monetary sanctions, including cease and desist orders, on MHSD licensed or certified facilities, as well as procedures for the appeal of an administrative action.

MHSD LCB is also responsible for the approval of 5150 facilities designated by the counties, throughout California, for the purpose of a 72-hour treatment and evaluation for individuals with a mental health condition. State law provides consistent standards

for protecting the personal rights of patients who are subject to involuntary detention and for providing services in the least restrictive setting appropriate to the needs of the patient.

Licensed facilities under the purview of DHCS are required to report deaths and other incidents and DHCS is authorized to conduct investigations in hospitals and other mental health treatment facilities, including 5150 facilities.

Disaster Response
The State of California Emergency Plan, authorized by the Emergency Services Act, defines a series of Emergency Functions, one of which is the Public Health and Medical Emergency Function (CA-EF 8). The California Department of Public Health (CDPH) and the Emergency Medical Services Authority co-lead DHCS and other departments charged with operationalizing CA-EF 8. The April 19, 2002 signed Administrative Order, implemented the State Emergency Plan between the former California Department of Mental Health (DMH) (realigned to DHCS effective July 1, 2012) and the California Office of Emergency Services (CalOES). Specifically, following a President-declared disaster, DHCS is required to prepare California's request to the Federal Emergency Management Agency (FEMA) and the Substance Abuse and Mental Health Services Administration (SAMHSA) for Crisis Counseling Assistance and Training Program (CCP) emergency mental health funding.

During a disaster, it is easy to identify health and medical needs (injuries, deaths, ambulance support, and medication support) as they are often deemed most critical, while behavioral health needs are often overlooked, as they are not considered immediate. However, following a disaster, behavioral health problems may involve distress, followed by a return to pre-exposure levels, and then a subsequent emergence of new disorders, such as Post Traumatic Stress Disorder (PTSD). The disaster may lead to the worsening of pre-existing conditions, such as serious mental illness in adults, serious emotional disturbance in children, and substance use disorders. The behavioral health services provided during a disaster are very different from the community-based mental health services that County Behavioral Health Agencies typically provide, which are more intensive behavioral health services provided in the community, a clinic, or hospital setting. In contrast, disaster behavioral health services are typically provided in evacuation shelters, public settings, or an individual's home or place of residence. The goal of disaster behavioral health services is to facilitate the recovery and return to resilience of survivors, responders, and the community.

As a result, County Behavioral Health Agencies are not always included in disaster planning and therefore are not familiar with the elements of disaster response. This can lead to challenges in coordinating behavioral health services since they are often provided by county behavioral health departments and community based providers.

California has experienced several natural disasters over the past several years, including the wildfires in Lake and Calaveras counties in 2015, wildfires in Sonoma, Napa, Mendocino, Butte, Yuba, Los Angeles, and Ventura counties during 2017, and debris flow in Santa Barbara in 2018. In addition to these natural disasters, California has also experienced or been affected by mass casualty incidences such as the San

Bernardino shooting in December 2015 and the Las Vegas shooting in October 2017. Each of these disasters triggers a response by DHCS' MHSD to provide support to counties. The response varies from providing resource materials to affected counties and collecting status updates of impacted mental health facilities, to developing applications for CCP funding.

During FY 2017-18, California received two Presidential Disaster Declarations for the northern California wildfires in October 2017 and the southern California wildfires and mudslides in December 2017 through January 2018. DHCS applied for and received two CCP grants. In response to the Northern California wildfires, California received a total of $7.5 million to support crisis counseling services in Butte, Mendocino, Napa, Nevada, Sonoma, and Yuba counties. This grant is estimated to serve 20,000 individuals. Furthermore, due to the Southern California wildfires and debris flow, California received a total of $2.7 million to support crisis counseling services in Los Angeles, Ventura, and Santa Barbara counties. This grant is estimated to serve 7,600 individuals.

DHCS explains that while federal funding is available for services in response to an emergency, this request for resources will support the significant workload associated with coordinating these services at the state level.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this Budget Change Proposal and respond to the following:

1. Please explain the increase in workload associated with "unusual occurrences," and the justification for the number of new positions being requested to support this increased workload.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional debate and discussion.

This agenda and other publications are available on the Assembly Budget Committee's website at: https://abgt.assembly.ca.gov/sub1hearingagendas. You may contact the Committee at (916) 319-2099. This agenda was prepared by Andrea Margolis.